Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUSAN VANDEWATER MD
SUITE 250
3100 TIMMONS LANE
HOUSTON TX 77027

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative
Box Number 45

MFDR Tracking Number
M4-11-2239-01

MFDR Date Received
February 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay claim in full for services rendered even after a request for reconsideration was submitted."

Amount in Dispute: $254.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office agrees that the services provided was at the request of the Designated Doctor (Exhibit 1); however the charges submitted are still retrospectively reviewed and audited per the Division's rules and payment policies. The Office will maintain its denial for HCPCS code A4556 for 97- payment is included in the allowance for another service/procedure as code is an item or service for which payment is bundled into payment for other physician services. (Exhibit II). Further review of the Office visit charge billing with CPT 99204, the requestor was referred to perform diagnostic testing only and has failed to document necessity to perform an Evaluation and Management service when not requested to do so by the carrier or Designated Doctor nor is the documentation sufficient to support the level of Evaluation and Management code billed. Therefore the Office feels that reimbursement is not warranted at this time for this service and will maintain its denial for 50-These are non-covered services because this is not deemed a medical necessity by the payer."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2010	99204, 95861, 95900 and 95904	$229.37	$0.00
September 8, 2010	A4556	$25.00	$15.94
TOTAL		$254.37	$15.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer
   - 97 – Payment is included in the allowance for another service/procedure
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - T14 – Appeal/reconsideration based on medical necessity. You may submit request for IRO review no later than 45 days from notice
   - Note: The designated doctor only referred the patient for the diagnostic testing which the designated doctor can only refer the patient for testing not for consul/E&M charges are not supported or requested service.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the requestor bill in conflict with the NCCI edits?
4. Did the insurance carrier issue payment for CPT codes 95861, 95900 and 95904 pursuant to 28 Texas Administrative Code §134.203?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

   Review of the submitted documentation finds that there are unresolved issues of medical necessity for disputed CPT code 99204 on the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue of medical necessity has been resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that CPT code 99204 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.
3. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT codes 99204, 95861, 95900, 95904 and A4556 rendered on September 8, 2010. The division completed NCCI edits to identify any edit conflicts that would affect payment. The following was identified: No NCCI edit conflicts were identified, therefore the disputed charges, 95861, 95900, 95904 and A4556 will be reviewed pursuant to 28 Texas Administrative Code §134.203.

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   The requestor seeks reimbursement for CPT codes 95900 and 95904. The MAR amount for the professional services indicated above is as follows:

   CPT code 95900 x 2 units = a MAR amount of $80.98 x 2 units = $161.96. The insurance carrier issued payment in the amount of $161.97; therefore no additional reimbursement is due.

   CPT code 95904 x 3 units = a MAR amount of $71.26 x 3 units = $213.77. The insurance carrier issued payment in the amount of $213.75; therefore no additional reimbursement is due.

5. Per 28 Texas Administrative Code §134.203 "(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   The requestor seeks reimbursement for HCPCS codes A4556. The MAR amount for Healthcare Common Procedure Coding System (HCPCS) Level II code A is as follows:

   The Medicare DMEPOS fee schedule for HCPCS code A4556 is $12.75 multiplied by 125% = a MAR amount of $15.94, therefore this amount is recommended.

6. Review of the submitted documentation finds that the requestor is entitled to an additional reimbursement in the amount of $15.94.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15.94.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.